# MEDICAL NUTRITIONAL THERAPY PROGRAM
# REQUEST TO ADD SUPPLEMENT TO APPROVED FORMULARY

Advance Approval Required - All sections must be completed in a typed or computer generated format.

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|---|---|
| NAME OF SUBRECIPIENT: | |
| SERVICE: | FUND: |
| CONTRACT NO: | CONTRACT TERM: |

**FORMULARY ADDITION REQUEST:**

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|---|---|
| **SUPPLEMENT NAME:** | |
| **APPROXIMATE COST:** | |

**JUSTIFICATION (Please provide a detailed description of how the supplement is related to the treatment of HIV. At least two evidence-based peer-reviewed journal articles must be included with submission):**

**By:** _____ _____ _____ _____
**Clinician Name** **Licensure** **Signature** **Date**

**Must be approved by applicable Agency clinician (MD, DO, NP, PA, Pharmacist)**

**Submit to RWGA Grants Management via email hivacct@phs.hctx.net**

**(Submitted by)**
**Name** _____ **Fax #** _____ **Phone #** _____

**Signature** _____ **Email** _____ **Date** _____

**All formulary addition requests will be reviewed quarterly by the Clinical Quality Management Committee. For information on meeting dates, send email to cmartin@phs.hctx.net**

☐ **APPROVED** ☐ **DISAPPROVED**

_____ _____
**Manager, Ryan White Grant Administration (RWGA)** **Date**

| | |
|---|---|
| **FOR RYAN WHITE GRANT ADMINISTRATION USE ONLY:** | **Date of CQM Committee Meeting:** |
| **Date Posted to MNT Request Log & initials:** | **Date received from QM:** |